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	085052	A. BUILDING _____ B. WING _____	09/05/2017

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from August 28, 2017 through September 5, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 110. The survey sample totaled thirty three (33). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; CNA - Certified Nurse's Aide; NP - Nurse Practitioner; PT - Physical Therapy / Physical Therapist; SW-Social Worker; SDS-Supply Distribution Staff ADLs (Activities of Daily Living) tasks such as eating, bathing, toileting and dressing; ADL Self-Performance - Extensive Assistance: resident involved in activity, staff provide weight-bearing support; - Limited Assistance: resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; - Supervision: oversight, encouragement or cueing; - Total Dependence - full staff performance every time activity performed; Ambulation - moving about; walking; Anticoagulant - medication to prevent the coagulation (clotting) of blood;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/25/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Antifungal - medication to treat fungus;
Arthritis - joint disease causing pain;
Bed Mobility - moving, turning, sitting in bed;
Bilateral - both sides;
Blood pressure - the measure of the force of blood against the walls of a blood vessel;
Braden Scale - tool used to assess a patent's risk of developing a pressure ulcer (the lower the score the higher the risk for developing pressure ulcer);
Broda Chair - high back wheelchair that tilts and reclines;
cc (Cubic Centimeter) - unit of liquid volume, 5 cc equals 1 teaspoon;
cm (Centimeter) - a metric measurement of length; 1 centimeter = 0.39 inches;
CDC - Centers for Disease Control and Prevention;
Cognition - mental processes, thinking, memory;
Cognitively Impaired - mental decline including losing the ability to understand, talk or write;
Delusions - a belief held with strong conviction despite evidence to the contrary;
Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
Diabetes Mellitus (DM) - disease where blood sugar levels are too high;
Diflucan - medication used to treat yeast and fungal infections;
DTI-deep tissue injury;
Ecchymosis - skin color change from damage to blood vessels;
Edema - swelling;
1+ = can press down 2 mm or less, slight pitting, indentation disappears rapidly;
2+ = can press 2-4 mm, somewhat deeper pit, indentation disappears in 10-25 seconds;
3+ = can press down 4-6 mm, pit noticeably

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F 000	Continued From page 2 deep and may last more than a minute; 4+ = can press down 6-8 mm, pit very deep and lasts over 2 minutes; e.g. - for example; eMAR - Electronic Medication Administration Record; EMR - Electronic Medical Record; Eschar-hard dead tissue that is tan, brown or black; Excoriation - abrasions to skin; Foley catheter - tube held in the bladder by a small balloon to drain urine: size of balloon can range from 10 cc to 30 cc: tube size includes 16, 18, 20 French with diameter of tube larger as the number increases; Fungal - yeasts or molds; Heel Protector/Boot - foam boot device to lift heel off mattress; Hospice - care for terminally ill; i.e. - that is; Immobile - not being able to move around; Incontinence - loss of control of bladder and/or bowel function; INR (International Normalized Ratio) - blood test to monitor effect of anticoagulants; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); Med Pass - high calorie liquid drink; mL (milliliters) - unit of liquid volume, 5 ml equals 1 teaspoon; mm-millimeter-unit of length; Mobility - moving around; Moderate Cognitive Impairment - decisions poor, cues / supervision required; Namenda - medication to slow progression of dementia; N/A - not applicable; Offload heels - raising feet (usually on pillows) so heels don't touch the mattress;	F 000		

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F 000	Continued From page 3 PASSR (Preadmission Screening and Resident Review) - screening for signs of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions so if in a nursing home they receive all necessary services for their condition; Patent - clear, unobstructed; POS (Physicians' Order Sheet) - monthly report of active physicians' orders; Pressure Injury Wound - area of injury caused by prolonged pressure on the skin; The staging of pressure injury wounds are as follows: - Stage 1 Pressure Injury: Intact red skin often over a boney area that does not turn white / light (does not blanche) when pressed; which may appear differently in darkly pigmented skin; - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present; - Stage 3 Pressure Injury: Open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible but does not hide the extent of tissue loss; - Stage 4 Pressure Injury: Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen. Rolled edges, undermining, tunneling often occur. Slough or eschar may be visible; - Unstageable: Actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed. Stable eschar (i.e. dry, adherent, intact without redness or movement) on	F 000		

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the heel or limb with impaired blood flow should not be softened or removed;
- Deep Tissue Pressure Injury: Intact or non-intact deep red, maroon, purple discoloration that does not turn white/light when pressed or skin separation revealing a dark wound bed or blood filled blister. Pain and temperature change often appear before skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss;
PRN - as needed;
Psychiatrist - physician for treatment of mental disorders;
Psychological-related to emotional and mental state of a person;
ROM (Range of Motion) - extent to which a joint can be moved safely;
Schizophrenia-disorder that affects persons ability to think, feel and behave clearly;
Serous - clear, thin wound drainage;
Severe Cognitive Impairment - unable to make own decisions;
Shear/Shearing Force - friction with reduced blood flow to the tissue under the skin from sliding down, or being pulled across, the bed;
Skin Prep - liquid dressing for intact skin to form protective film;
Slough-yellow, tan, gray, green or brown soft dead tissue;
Thombocytopenia - condition with low platelets in the blood, platelets help the blood to clot;
Timed (or scheduled) toileting program - technique of bladder training in which the resident is instructed to urinate according to a predetermined schedule;

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F 000	Continued From page 5 TB-tuberculosis-lung infection; x - times.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R294 and 291) out of 33 sampled residents the facility failed to ensure resident preference was determined for bathing. The facility's system on 1 out of 3 units was to schedule bathing by room and bed number twice a week, once on evening shift and once on day shift. Findings include: 1. The following was reviewed in R294's clinical record: 8/25/17 - Resident admitted to facility per EMR. 8/28/17 - EMR documented a shower on the evening shift.	F 242	a. R294 and R291 were not harmed by this deficient practice. Residents were interviewed for preferences for showers. b. All residents have the potential to be affected by this deficient practice. c. A root cause was conducted to determine shower/bathing preferences were identified for like residents. It was determined that the facility did not have a system in place for shower/bathing preferences during the admission process. The Nursing Staff will interview all new admissions during the admission process to determine preferences for showers/bathing (Attachment #1). Nursing staff will be educated on this new practice.	11/6/17

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F 242	Continued From page 6 8/31/17 2:00 PM - Interview with resident revealed that s/he had not been told the bath schedule but that s/he had one shower since admission. R294 stated that she prefers a shower at night. 8/31/17 - EMR documented a shower on the day shift. During an interview with E18 (Rehoboth UM) on 8/31/17 at 2:37 PM E18 revealed that baths were scheduled by room number and residents could ask to have it changed. 9/1/17 - Posted schedule for (resident's room number) Friday day shift and Monday evening shift. 9/1/17 - EMR documented shower on day shift. 9/1/17 - Admission MDS documented the resident had moderate cognitive impairment and was alert and oriented. During an interview with E19 (Rehoboth UM) on 9/1/17 at 11:21 AM E19 stated that residents were scheduled for a rotating day shift and evening shift bath based on room number and residents could request to change that. E19 confirmed that residents were not assessed for bathing preference on admission. During an interview with E2 (DON) on 9/1/17 at 2:30 PM E2 said that the laminated bathing schedule by room number was a guide and if the resident requested something different it could be changed. Determining resident preference for bathing without residents having to advocate for a	F 242	d. DON/designee will conduct random audits daily until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters.	

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F 242	Continued From page 7 preferred day or shift was discussed by surveyor. 2. The following was reviewed in R291's clinical record: 8/11/17 - According to EMR resident was readmitted to the facility from the hospital. 8/25/17 - EMR documented complete bed bath. 8/27/17 - EMR documented partial bed bath. 8/30/17 - EMR documented shower on day shift. During an interview with R291 on 8/30/17 at 11:40 AM the resident and a family member confirmed R291 had a shower that morning but that the facility did not ask what schedule was preferred. They thought the bathing schedule might be every three days. During an interview with R291 on 8/31/17 at 11:33 AM R291 revealed that s/he had been getting a shower and morning is the preferred time. During an interview with E18 (Rehoboth UM) on 8/31/17 at 2:37 PM E18 stated that baths were scheduled by room number and residents could ask to have it changed. During an interview with E19 (Rehoboth UM) on 9/1/17 at 11:21 AM E19 revealed that residents were scheduled for a rotating day shift and evening shift bath based on room number and residents could request to change that. E19 confirmed that residents were not assessed for bathing preference on admission. 9/1/17 - Posted schedule for (resident's room	F 242		

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F 242	Continued From page 8 number) Monday day shift and Thursday evening shift. During an interview with E2 (DON) on 9/1/17 at 2:30 PM E2 said that the laminated bathing schedule by room number was a guide and if the resident requests something different it could be changed. Determining resident preference for bathing without residents having to advocate for a preferred day or shift was discussed by surveyor. 9/4/17 (Monday) - bed bath documented in EMR. These findings were reviewed with E1 (NHA) and E2 on 9/5/17 at 2:00 PM.	F 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to meet the needs for one (R49) out of 33 sampled residents. Findings include: An observation was made at 9:22 AM on 8/29/17 of R49's over the bed light. The chain used to turn on the light was too short for R49 to reach while lying in bed. During an interview, at the	F 246	a. R49 over bed light chain was immediately repaired upon discovery. b. All residents have the potential to affected by this deficient practice. c. A root cause was conducted and it was determined that the facility did not have a system in place to audit bed light chains in all like rooms. A facility sweep was conducted by the maintenance	11/6/17

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F 246	Continued From page 9 same time, R49 explained that the chain could only be reached by standing. An observation was made at 10:15 AM on 8/30/17 of R49's over the bed light chain being too short to reach when lying in bed. During an interview on 9/5/17 at 10:41 AM, E2 (DON) confirmed the finding and immediately notified the maintenance department for repair. This finding was reviewed with E1 (NHA) and E2 on 9/5/17 at 2:00 PM.	F 246	department and it was determined that there were no other bed light chains that were determined to be too short. d. Maintenance Director/designee will conduct random audits daily until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved	
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		11/6/17

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F 279	Continued From page 10 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation the facility failed to	F 279	1. a. R11□s care plan was immediately	

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F 279	Continued From page 11 develop an individualized comprehensive care plan based on identified needs with measurable goals for six (R11, R228, R5, R57, R198 and R15) out of 33 sampled residents. Findings include: 1. Review of R11's clinical record revealed: 4/13/17 - R11's PASRR Level II Determination of Mental Illness Recommendation documented that R11 required specialized services. The recommended services included that R11's mental health and related mental health medications must be monitored on an ongoing and monthly basis by a psychiatrist and supportive counseling to be provided by a licensed mental health professional. Review of R11's current care plans revealed there were no care plans developed that identified R11's need for specialized services. During an interview on 9/5/17 at 12:13 PM with E2 [DON] it was confirmed that R11's current care plans did not address R11's specialized services and that E3 (SW) was currently working on developing a care plan. During an interview on 9/5/17 at 12:20 PM with E3 it was confirmed that a care plan addressing R11's need for specialized services was created on 9/5/17 and a copy was presented to the survey team. 2. Review of R228's clinical record revealed: R228's care plan included goals that were not complete, measurable or resident centered: a. Complications related to blood pressure included the goal: Blood pressure will be maintained within her own normal range [what is	F 279	corrected for specialized services upon discovery. b. All residents who have a PASRR Level 2 Determination have the potential to be affected by this deficient practice. c. A root cause analysis was conducted and it was determined that the facility failed to update the care plan for specialized serviced based off of the PASRR Level 2. A facility sweep was conducted and it was determined there were no like residents. The Social worker will notify the Psychiatrist/NP Provider weekly on all new PASSR level 2□s and a care plan will be updated for specialized services. d. The Social Worker/designee will conduct weekly audits until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. 2. a. R228 care plan was immediately updated upon discovery. b. All residents have the potential to be affected by this deficient practice c. A root cause analysis was conducted and it was determined that the residents care plan was not updated showing measurable goals and resident centered. A facility was conducted and it was determined that identified care plans needed to be more measurable and resident centered.	

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F 279	Continued From page 12 the range]. b. Pain included the goal that pain will be controlled to an acceptable level [what is acceptable for this resident]. c. ADLs included the goal for staff to assist with ADLs and encourage participation [this is a staff goal, not a resident goal]. d. Actual pressure ulcer right heel included the goal that the area will show no signs of infection [goal did not include improvement/healing by reduction in size]. 3. Review of R5's clinical record revealed: R5's care plan included goals that were not individualized and/or measurable: a. Complications related to blood pressure included the goal: Blood pressure will be maintained within his/her own normal range [not individualized for this female resident, what is the range]. b. GI [gastrointestinal] distress included the goal symptoms will be managed [not have symptoms at all, or relief within specified time frame after PRN treatment]. c. Pain included the goal that pain will be controlled to a a level that is comfortable [what is comfortable for this resident]. d. Delusions included the goal to have less episodes of unrealistic thoughts [how many is less]. 4. Review of R57's clinical record revealed R57's care plan included goals that were not individualized and/or measurable: a. Complication from hepatic (liver) failure included goal to not have complications [what are they]. b. Pain included the goal that pain will be controlled to a a level that is comfortable [what is	F 279	d. The Unit Managers/designee will conduct random resident care plans weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. 3. a. R5□s care plan was immediately updated upon discovery. b. All residents have the potential to be affected by this deficient practice c. A root cause analysis was conducted and it was determined that the residents care plan was not updated showing measurable goals and resident centered. A facility was conducted and it was determined that identified care plans needed to be more measurable and resident centered. d. The Unit Managers/designee will conduct random resident care plans weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. 4. a. R57□s care plan was immediately updated upon discovery. b. All residents have the potential to be affected by this deficient practice c. A root cause was conducted and it was determined that the residents care plan was not updated showing	

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F 279	Continued From page 13 comfortable for this resident]. 5. Review of R198's clinical record revealed: R198's care plan included goals that were not individualized and/or measurable: a. Complications related to blood pressure included the goal: Blood pressure will be maintained within his/her own normal range [not individualized for this female resident, what is the range]. b. Pain included the goal that pain will be controlled to an acceptable level [what is acceptable for this resident]. Cross Refer F315 6. Review of R15's clinical record revealed: R15's care plan for Skin and Urinary did not include a urinary catheter goal or approaches. During an interview on 9/5/17 at 10:33 AM, after providing a printed copy of the current care plan, E2 (DON) confirmed there was nothing in the care plan about a foley catheter. The facility failed to develop an individualized foley catheter plan for R15. These findings were reviewed with E1 (NHA) and E2 on 9/5/17 at 2:00 PM.	F 279	measurable goals and resident centered. A facility was conducted and it was determined that identified care plans needed to be more measurable and resident centered. d. The Unit Managers/designee will conduct random resident care plans weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. 5. a. R198□s care plan was immediately updated upon discovery. b. All residents have the potential to be affected by this deficient practice c. A root cause was conducted and it was determined that the residents care plan was not updated showing measurable goals and resident centered. A facility was conducted and it was determined that identified care plans needed to be more measurable and resident centered. d. The Unit Managers/designee will conduct random resident care plans weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. 6. a. R15□s care plan was	

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F 279	Continued From page 14	F 279	immediately updated upon discovery. b. All residents have the potential to be affected by this deficient practice c. A root cause was conducted and it was determined that the residents care plan was not updated showing measurable goals and resident centered. A facility was conducted and it was determined that identified care plans needed to be more measurable and resident centered. d. The Unit Managers/designee will conduct random resident care plans weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. F280	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280		11/6/17

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F 280	Continued From page 15 plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

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F 280	Continued From page 16 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and observation it was determined that the facility failed to revise the care plan for one (R228) out of 33 sampled residents to reflect the resident's current status. Findings include: Cross Refer F314 Review of R228's clinical record revealed the following care plans were not revised when resident behavior and/or physicians' orders changed: a. 6/13/17 - PT Evaluation and Plan of Treatment included that R228 was at baseline level of supervision for transfers and ambulation with a	F 280	a. R228□s care plans were immediately updated upon discovery. b. All residents have the potential to be affected by this deficient practice c. A root cause was conducted and it was determined that the residents care plan was not updated showing measurable goals and resident centered. A facility was conducted and it was determined that identified care plans needed to be more measurable and resident centered. d. The Unit Managers/designee will conduct random resident care plans weekly until 100% compliance is achieved	

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F 280	Continued From page 17 rolling walker. 6/27/17 (9:18 PM) Nursing Note - Easily redirected at times when getting up and ambulating without assistance. 7/6/17 (9:15 AM) Nursing Note - Continued to be in wheelchair for mobility around the unit often stands unassisted, redirected often. 7/31/17 PT Note - Resident requiring maximum assistance to pull to standing position. 8/28/17 - 9/5/17 Observation throughout the survey discovered R228 made no attempt to stand. Current care plan problem for safety hazard as evidenced by standing and ambulating without assistance (initiated 6/19/17) not updated after behavior stopped. b. July, 2017 - CNA documentation ADL Category Report showed decline in the resident's ability to move (locomotion) around the unit. Until the week of July 21 - 26 R228 needed limited assistance. Starting the week of July 22 - 28, the level of assistance increased to extensive. 8/28/17 - 9/5/17 - Observation throughout the survey found R228 made no attempt to self-propel looking for exits. Current care plan problem for safety hazard (initiated 6/19/17) as evidenced by exit seeking behavior, wanders aimlessly through the building looking for exits. Not updated when behavior stopped.	F 280	for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

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F 280	Continued From page 18 c. 8/17/17 - Physicians' orders included bilateral heel boots (right on actual DTI and left as preventative measure). Review of care plan problem for Potential for pressure ulcer (initiated 6/19/17) related to decreased mobility did not include the left heel boot as a preventative measure. These findings were reviewed with E1 (NHA) and E2 (DON) on 9/5/17 at 2:00 PM.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure wound care services were provided by qualified personnel for one (R228) out of 33 sampled residents. Findings include: Cross Refer F314 Review of R228's clinical record revealed: Weekly wound assessments performed by E10 (NP - wound care consultant) on August 3,10, 24 and 31 (no August 17 weekly wound assessment in the record).	F 282	a. R228 was not harmed by this deficient practice. b. All residents with wounds have the potential to be affected by this deficient practice. c. A root cause analysis was conducted and it was determined that E10 failed to use proper infection control procedures when assessing and applying skin prep to a wound. It was also determined that the facility did not have the weekly wound noted loaded into the electronic medical record. Education was provided to E10 on proper infection control procedures when	11/6/17

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F 282	Continued From page 19 8/24/17 Wound Assessment Note - Contained the exact same wording as 8/10/17 regarding right heel wound description. 8/31/17 (around 10:30 AM) - E23 (facility wound nurse) and E10 were conducting wound rounds together. E23 acknowledged the surveyor's desire to observe R228's treatment and said s/he would get the surveyor who waited at the nursing station. 8/31/17 (11:00 AM) - surveyor observation of treatment to right heel by E10: - E10 had already used a mirror to assess and measure R228's heel DTI by the time the surveyor was informed and arrived at the resident's room. It was unclear if the mirror was cleaned before use. - While opening a skin prep packet, E10 touched the mirror to the resident's heel, and used it to see the heel while applying skin prep. E10 placed the mirror (without cleaning) into his/her lab jacket pocket. - After applying skin prep, E10 replaced R228's sock almost immediately without checking to make sure the skin prep was completely dry to avoid the sock sticking to the skin on removal. - Wrong heel (left) was assessed and treated with findings documented as the right heel. - The right heel DTI was not assessed or treated. During an interview with E10 on 8/31/17 at 11:08 AM, E10 confirmed the mirror was placed in the pocket without cleaning. E10 proceeded to use disinfectant wipes to clean the mirror and personal cell phone, also in the pocket. During a telephone interview with E10 on 9/1/17 at 10:00 AM, E10 confirmed the documentation of	F 282	assessing and treating wounds. The facility completed an immediate audit to assure all wound documentation was in place in the electronic medical record. No further omissions were identified. d. The Unit Managers/designee will conduct random audits on weekly wound assessments to assure that the documentation is in the electronic medical record until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. The Staff Educator/Designee will conduct random audits for proper infection control procedures when assessing/conducting wound treatments weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

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F 282	Continued From page 20 the weekly wound rounds conducted on August 17 was never sent to the facility. E10 confirmed that the content of the previous assessment flows into the new assessment and the wording needs to be changed to reflect the resident's current status. E10 had no explanation for why the left heel was assessed and treated and not the right one the day prior. During an interview with E2 (DON) on 9/1/17 around 2:10 PM, E2 provided a copy of the August 17 wound round documentation along with the following: - 8/24/17: addendum that left heel not assessed. Interventions in place was missing the air mattress ordered 8/17/17. - 8/31/17: addendum that left heel assessed with description. Also that right heel not assessed. - 9/1/17: new note with right heel assessment findings, along with left heel findings from day prior. These findings were reviewed with E1 (NHA) and E2 on 9/5/17 at 2:00 PM.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide toileting or incontinence care for three (R77, R228 and R273) out of 33 sampled residents according to the plan of care. Findings	F 312	a. R77, R228 and R273 were not harmed by this deficient practice. R273□s toileting schedule was created upon discovery. b. All residents who are on a toileting	11/6/17

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F 312	Continued From page 21 include: 1. Review of R77's clinical record revealed: Current toileting flowsheet in the CNA documentation binder included R77 would be toileted / provided incontinence care before breakfast, after breakfast, before lunch, after lunch, before dinner, after dinner, and before bedtime. Observations of R77 found that the resident was seated in a Broda chair in the dining/activity room and not taken to the toilet (or offered) after breakfast/before lunch: - 8/29/17: 9:30 AM - 1:00 PM. - 8/31/17: 8:30 AM - 1:30 PM. - 9/1/17: 7:50 AM - 1:25 PM. Observation of incontinent on 9/1/17 at 1:30 PM discovered the resident buttocks were not reddened. 2. Review of R228's clinical record revealed: Current toileting flowsheet in the CNA documentation binder included that R228 would be toileted before breakfast, before lunch, before dinner, before bedtime and second check on night shift. Observations found R228 seated in a wheelchair in the dining/activity room and not taken to the toilet (or offered) before lunch: - 8/28/17: 9:30 AM - 1:25 PM - 8/31/17: 8:50 AM - 1:55 PM 3. Review of R273's clinical record revealed:	F 312	program have the potential to be affected by this deficient practice. c. A root cause analysis was conducted throughout the facility and it was determined that facility failed to ensure that the above residents were not offered to tiolet based on the tioleting schedule devised by the facility. Nursing staff will be educated on following the toileting scheduled devised by the facility and to offer toileting. d. Unit Managers/designee will conduct random audits weekly to assure that the resident toileting schedule is followed until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

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F 312	Continued From page 22 6/26/17 - Care plan problem for incontinence included the approach to check and change every 2 hours and PRN. During an interview with E14 (UM) on 8/29/17 at 10:50 AM, E14 confirmed that the resident had no toileting flowsheet in the CNA documentation binder since she is a "check and change." E14 added that there was no way staff can get her on and off the toilet. R273 is transferred using a mechanical lift. Observations found R273 seated in a wheelchair in the dining / activity room without being checked and/or changed: - 8/29/17: 9:30 AM - 1:45 PM. - 8/31/17: 8:30 AM - 2:00 PM. - 9/1/17: 8:40 AM - 1:30 PM. Observation on 9/1/17 around 1:40 PM discovered R273 yelled and cursed at staff when being returned to bed using the mechanical lift and, after incontinent care, was found to have no buttock redness. During an interview with E14 on 9/1/17 at 2:32 PM E14 offered no comment when informed about the long time frame residents were seated in the dining / activity room without incontinent care. These findings were reviewed with E1 (NHA) and E2 (DON) on 9/5/17 at 2:00 PM.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		11/6/17

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F 314	Continued From page 23 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to prevent the development of a pressure ulcer for one (R228) out of 33 sampled residents. Prior to a fall on July 21, 2017, R228 was able to transfer from bed to chair with supervision, ambulate using a rolling walker and self-propel in a wheelchair. After the fall and discontinuation of a medication for dementia R228's ability to stand up, ambulate and self-propel in the wheelchair declined. The facility failed to reassess R228's risk for developing a pressure ulcer after this decline and did not evaluate for the implementation of additional preventative measures resulting in the resident developing a deep tissue pressure injury [DTI]to the right heel. Additionally the facility also failed to provide the necessary treatment and services to promote healing after the development of the right heel DTI. Findings include: 1. Review of R228's clinical record revealed:	F 314	a. R228 is no longer a resident in the facility. b. All residents who exhibit a functional decline have the potential to be affected by this deficient practice c. A root cause analysis was conducted and it was determined that the facility failed to prevent the development of a heel pressure ulcer. A facility sweep was conducted and no other residents were identified as having a heel wound after a functional decline. The Nursing Management Team, along with the Medical Director, will meet weekly at the facility high risk meeting to review all residents who have been identified as having a functional decline to determine that all interventions are in place. The review will be documented in the resident□s medical record and the resident care plan will be updated to reflect any new interventions that will be in	

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F 314	Continued From page 24 Cross Refer F279, Example 2, F312, Example 2, and F282. a. Pressure Injury Development 6/13/17 - Admission to facility with multiple diagnoses including dementia, brain hemorrhage, diabetes, arthritis and thrombocytopenia. 6/13/17 - Admission physical assessment documented heels pink and blancheable, no pressure injury wounds. Weight 181 pounds. 6/13/17 - Admission Braden Score (skin risk assessment) score was 21 indicating R228 was not at risk for developing pressure ulcer. 6/13/17 - Physicians' orders included: Encourage off load heels every shift; Encourage turn / reposition every 2 hours and PRN; and weekly skin checks on Tuesday evenings. 6/13/17 PT Evaluation and Plan of Treatment - For treatment period ending 6/27/17 R228 was at baseline level of supervision for transfers and ambulation with rolling walker. 6/16/17 (10:28 PM) Nursing Note - R228 had +1 edema to both ankles, encourage to elevate both legs. 6/18/17 (10:11 PM) Nursing Note - Resident with +2 edema to both ankles. 6/19/17 - Care plan problems included: - Potential for pressure ulcer related to decreased mobility had the goal to be free from open areas at pressure points. Approaches included pressure reducing mattress (usual mattress on the bed), skin checks every 2 hours and PRN; and turn	F 314	place. d. DON/designee will conduct weekly audits on all residents who have demonstrated a functional decline based on assessment to determine that additional preventable measures are in place weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

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F 314	Continued From page 25 and reposition every 2 hrs and PRN. - Fluid Maintenance included approaches to elevate legs above heart level as tolerated / allowed; and apply TEDS (compression stockings) as ordered and as resident tolerates. (TEDS were discontinued 7/11/17 since resident would roll them down and not wear properly.) 6/27/17 PT Encounter Note - Resident ambulated up to 125 feet x 2 with rolling walker. Transfer from wheelchair, standard chair and recliner chair all with supervision. 7/6/17 (9:15 AM) Nursing Note - Continued to be in wheelchair for mobility around the unit often stands unassisted, redirected often. 7/11/17 - Braden score was 19 and R228 remained not at risk for developing pressure ulcers. 7/21/17 (3:11 PM) Nursing Note - R228 was walking around the dining room unassisted, staff member attempted to help resident sit back in chair- resident sat buttocks on the edge of chair and slid down to the floor, did not hit head. 7/21/17 - Physicians' orders stopped Namenda. 7/28/17 (12:06 PM) Nursing Note - Increase in difficulty standing and needing more staff assistance. Resident occasionally complaining of pain all over hips, knees, ankles. 7/30/17 PT Note - Poor weightbearing right ankle. Noted shoes tight on feet with current level of edema. Spoke with nursing aides regarding limiting use of these shoes.	F 314		

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F 314	Continued From page 26 7/30/17 PT Evaluation and Plan of Treatment - R228 bilateral lower extremity edema from knees to feet with right ankle pain reported during ROM and during weightbearing. Current mobility level is a significant decline from previous level of function at end of course of therapy. Decline appears to be consistent with leg edema, right ankle pain and strength deficits in legs. Recommended to nursing that R228 will need two person assistance for transfers on nursing unit. 7/31/17 PT Note - Resident avoiding weight bearing on right leg, requiring maximum assistance to pull to stand. Ultrasound to right ankle for edema and pain control. Continues to grimace with passive ROM. There was no evidence in the clinical record that a skin risk assessment (i.e., Braden) was performed after R228's mobility declined. 8/1/17 Weekly Skin Check- Intact no comment noted. 8/2/17 (7:42 AM) Nursing Note - Informed by PT to assess right heel purple discoloration 4 cm by 4 cm partially fluid filled area. NP aware and new order to apply skin prep to both heels twice a day, daughter aware. 8/3/17 Wound Note - Seen for evaluation and treatment of right heel wound. Current treatment skin prep. Wound measuring 2.5 cm by 3.0 cm with 75% of wound base deep purple ecchymosis and 25% serous blister. Edges adherent to wound base. No drainage. No evidence of pain when area palpated. Assessment pressure ulcer of right heel, unstageable due to suspected Deep Tissue Injury (DTI). "Deemed unavoidable due to	F 314		

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F 314	Continued From page 27 patient overall decline, would self propel in wheelchair." PT initiated. Plan to cleanse affected area with NSS or wound cleanser, apply skin prep twice a day. Off load pressure to affected area. Continue repositioning according to facility policy. Interventions in place: redistribution mattress, wheelchair cushion. Recommend heel boots and no shoes except for therapy. [The term suspected DTI was changed in 2016 to DTI, dropping the word suspected. It was unclear why the reason for self-propelling was listed as contributing to the development of the wound, when the resident stopped the behavior weeks before the appearance of the wound.] 8/3/17 - Physicians' orders included no shoes except for therapy, right heel boot and skin prep to both heels twice a day. Review of most recent pertinent laboratory tests with (reference range): 4/10/17: Albumin 3.5 (3.5-5.0), Total protein 6.0 (6.3-8.2) 7/5/17: Hemoglobin A1C 6.6 (4.0-6.0), Platelets 182 (165-429) July, 2017 - August, 2017 - Review of CNA documentation revealed: - Bedbath received: August 1 the evening before DTI discovered on right heel. There was no documentation in the record regarding any skin issues. - Offload heels: Every shift checked off except refusal on evenings July 19, 21, 25, 26, 28. - Skin check every 2 hours and PRN: Every shift except day shift August 3 when resident was combative - Encourage turn/reposition documented as every 2 hours and PRN: done on evenings and nights	F 314		

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F 314	Continued From page 28 during time frame. Despite the fact that the resident was non-compliant with TED stockings and intermittently refused to offload heels on pillows (kicked out pillows), there was no evidence in the clinical record that heel boots were considered. During an interview with E11 (LPN) on 8/31/17 at 2:22 PM to discuss the use of shoes and the resident's edema prior to the development of the DTI on 8/3/17, E11 said R228's daughter had brought in several pairs of mesh-type shoes of larger sizes when the resident's feet were more swollen. During an interview with E12 (day shift CNA who cared for R228 on July 30 and 31, Aug 1 and 2) on 8/31/17 at 2:27 PM when asked to think back to when R228 was wearing shoes and how they fit when she had swelling, E12 stated "When they [feet] got swollen we didn't put them back on." When asked what interventions were in place before the pressure injury wound developed, E12 said to offload the heels. The CNA explained that 3 pillows were needed since 1 didn't raise them [the heels] high enough. During an interview with E13 evening shift CNA who cared for R228 on July 28 and August 1 on 8/31/17 at 3:37 PM when asked how R228's heels were elevated before the pressure ulcer, E13 stated pillows, but the resident would push them out. When the resident did that "I would document she refused. " [E13 was the only CNA who documented refusal of offloading heels.] The surveyor said R228 had a bath on July 28 and Aug 1 when E13 worked and asked the CNA to describe her heels at that time, E13 stated "I do	F 314		

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F 314	Continued From page 29 not remember." The facility failed to reassess R228 after a decline in function resulting in the development of a right heel DTI and failed to implement additional preventative measures resulting in harm to R228. Cross Refer F279, Example 2 and F282 b. Treatment of Pressure Injury Ulcer 8/3/17 - Care plan problem for Actual pressure ulcer right heel included the goal that the area will show no signs of infection. Heel boot to right foot. Measure weekly on rounds. Skin check every 2 hours, pressure relieving device to bed/chair. Turn and reposition every 2 hours and PRN. 8/4/17 - Right heel boot initiated after product available. 8/8/17 Weekly Skin Check - Intact, no comment noted. 8/9/17 Nutrition Note - 4.8% (8 lbs) loss over past 30 days, now 172.4. Will add Med Pass 90 mL twice a day to promote wound healing of DTI. Liberalize meal plan. 8/10/17 PT Note - Multiple attempts with sit to stand transfers. She will initially make attempt but when PT tried to assist resident refused, unable to perform transfer independently. Did accomplish 1 sit to stand with maximum assistance. Attempted to take some steps but resident refused and sat down. Other therapy staff familiar with R228 noted significant confusion and worsening of the resident's cognitive status.	F 314		

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F 314	Continued From page 30 8/10/17 Wound Note - Unstageable right heel pressure ulceration measuring 3 cm by 4 cm with wound base 100% fading purple ecchymosis. 8/10/17 - Skin risk assessment score was 16 indicating R228 was at risk for developing pressure ulcers for the 8/10/17 Significant Change MDS assessment. 8/10/17 Significant Change MDS Assessment - R228 still had moderate cognitive impairment and required extensive assistance with two persons for both bed mobility and transfer. 8/16/17 - Care plan meeting summary documented R228 had decline in recent weeks - not standing as well as in past and DTI to right heel. Namenda was discontinued at last psychotropic reduction meeting. Followed by [name of local cancer center] for platelets which have been normal. Had recent fall. 8/17/17 - Wound Note missing in the clinical record. [It was unclear if R228's right heel wound was assessed this week.] 8/17/17 - Physicians' orders included an air mattress for the bed, 15 days after the development of the pressure injury ulcer. 8/21/17 PT Note - Pt resistant to all efforts for ROM, especially bending left knee. Continue ultrasound to left heel to facilitate circulation and healing to blistered area with goal to improve functional transfer without discomfort. Left heel blood blister present. [R228 had a DTI to the right heel, yet this note documented left heel or was it a new DTI?]	F 314		

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F 314	Continued From page 31 8/22/17 PT Progress Report - Spoke with nursing / CNA staff on unit who report bilateral leg edema has decreased since starting therapy (7/30), but this has not improved R228's function. 8/24/17 Wound Note - exact same wording as 8/10/17 regarding right heel wound size and description. 8/28/17 (9:30 AM - 1:30 PM) - Observed R228 seated in wheelchair in dining / activity room without change of position. 8/29/17 PT Note - R228 very tearful during left knee flexion and not allowing passive ROM. But once resting resident was able to rest left leg in over 80% flexion (knee bent). Pulsed ultrasound to right heel for pain relief / circulation, heel blood blister (dry). After placing hands on rims of wheelchair resident able to propel self up to 15 feet at a time. Refused to use legs for propulsion, therefore leg rests in place. 8/29/17 Weekly Skin Check - Intact, no additional comments written. 8/31/17 (8:30 AM - 1:50 PM) - Observed resident seated in wheelchair without change of position in dining / activity room and own room during wound treatment. 8/31/17 (11:00 AM) - Observation of treatment to right heel by E10 (NP - wound care consultant) assessed and measured wound using mirror to visualize the DTI area on the outer side of the LEFT heel. After applying skin prep, NP replaced sock. [It was unclear why the NP assessed the left heel when it was the right heel that was the one being treated.]	F 314		

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F 314	Continued From page 32 8/31/17 (2:24 PM) - Observation of resident in bed with socks removed to look at both heels revealed DTI on left heel as seen when NP assessed earlier in day. Right heel with DTI on outer side heel that looks wider (larger) than left one. Skin intact on both heels, no open areas, purple / dark red discoloration. Review of August, 2017 CNA documentation revealed: - Right heel boot: signed off as done August 4 - 17. - Bilateral heel boots: signed off August 17 - 31 but wore one boot (due to unavailability) on August 22, 26 and 27 but did not indicate which foot it was used for. - Offload heels: Every shift checked off - Skin check every 2 hours and PRN: Every shift except day shift August 3 when resident was combative - Encourage turn/reposition every 2 hours and PRN: done on evenings and nights during time frame. It was also unclear why skin checks were signed off as being completed every 2 hours when there were observations on August 28 and 31 when the resident was continuously seated in the wheelchair for at least 4 hours. During a telephone interview with E10 on 9/1/17 beginning at 10:00 AM, when asked for the documentation of the August 17 weekly wound rounds, E10 said, "I am almost positive I saw" R228. E10 informed the surveyor that the file was not in the email sent to the facility, but did locate the document and would send it to E1 (NHA) to print to add to the clinical record. E10	F 314		

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F 314	Continued From page 33 confirmed that the right heel was the side being assessed weekly. When asked about the left heel DTI, E10 said, "They never told me about the left one." Surveyor requested an explanation of how a left DTI was noted by PT on 8/21, yet the 8/24 wound assessment did not identify it. E10 said, "It may have defaulted in from the week before when I assessed it." The NP clarified that the information from the previous assessment flows into the electronic document and must be changed to reflect the resident's current status. E10 offered no explanation when asked why, during wound rounds the day before, the left heel was assessed and treated with the findings documented as the right heel and that the right heel was not assessed or treated. When asked how E10 determined on 8/3/17 that R228's right heel DTI was unavoidable, E10 said the nurse informed him/her that the resident used heels to propel in the wheelchair and had a poor appetite. [The resident stopped self-propelling with feet in July.] During an interview with E14 (LPN, UM) on 9/1/17 at 10:43 AM when asked when s/he was aware of the blood blister on the left heel, E10 said "Yesterday when it was discovered by the wound team." Surveyor informed the UM that E10 assessed the left heel DTI and the right one was never looked at the day before. During an interview with E17 (PT) on 9/1/17 at 11:02 AM E17 informed the surveyor that R228's right heel was the one that was being treated and the PT wrote the wrong side on the 8/21 note. "I was working with her left knee and right heel. Last week it (DTI) was not there on the left heel." E17 stated s/he fixed the documentation.	F 314		

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F 314	Continued From page 34 The facility failed to provide weekly assessment and treatment for the right heel DTI. These findings were reviewed with E1 (NHA) and E2 (DON) on 9/5/17 at 2:00 PM.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based	F 315		11/6/17

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F 315	Continued From page 35 on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility initiated the use of an indwelling foley catheter without appropriate medical indication and in the absence of less invasive interventions. There was also a risk of infection due to repeated removal then reinsertion of catheters for one (R15) out of 33 residents. Findings include: Review of R15's clinical record revealed: 12/16/16 - Admission to the facility on 12/16/16 and to hospice on 1/6/17 for heart failure. 4/17/17 - Quarterly MDS - Resident not on a toileting program and was always incontinent of both bowel and bladder. 5/1/17 - 8/31/17 - Review of CNA Behavioral Flow Sheet for Refusing Care found only 6 occasions of refusal in this 3 month period. 7/13/17 - Quarterly MDS indicated R15 was cognitively intact and rejection of care was not exhibited. R15 required extensive assistance for toileting, a trial toileting program was completed and resident was always incontinent of bowel and bladder. 8/17/17 (12:04 PM) Nursing Note - Physician ordered a 16 foley catheter with 30 cc balloon was placed without complication.	F 315	a. R15 was not harmed by this deficient practice. R15□s chronic abdominal rash and perineal area continues to heel. b. All residents with foley catheters have the potential to be affected by this deficient practice. c. A root cause analysis was conducted and it was determined that the facility failed to obtain a foley catheter order without proper indication. The facility completed a sweep for like residents and no other residents were identified. The Staff Educator will inservice the nursing staff on clinical indications for foley catheters when clinical indications are identified. The Staff Educator will also educate nursing staff on other alternative interventions prior to obtaining an order for a foley catheter. d. DON/designee will conduct weekly audits on all residents who have foley catheters to determine if the foley catheter was clinically indicated weekly until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

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F 315	Continued From page 36 8/17/17 (1:17 PM) Wound Note - (Resident seen on weekly wound rounds for a fungal area to abdominal folds and groin.) Resident has fungal area in bilateral abdominal folds and in groin area. Resident continues with scattered areas in bilateral abdominal folds. Groin area has scattered openings with increased redness in periwound area. Area is significantly exacerbated by resident not allowing staff to change brief after incontinent episodes at times. In addition, resident also has had trials of oral abts (antibiotics) for yeast which is longstanding problem for resident, It is believed that condition will likely improve if urine is not present in the groin area. In addition, it is recommended that the brief be allowed to be left open at night while in bed to decrease moisture accumulation in abdominal folds as well. Will continue to follow on weekly wound rounds. 8/17/17 (2:25PM) Nursing Note - Resident yeast infection condition of skin worsening reported to the NP and new orders for 2 week trial of a 16 foley catheter and reevaluation at that time. Resident requesting to trial catheter to facilitate healing. Niece and Hospice notified of new orders. 8/18/17 (2:09 AM) Nursing Note - Previous shift (3-11) reported to (11-7) that the foley was leaking. 11-7 shift repositioned and re-inflated the balloon with no leakage noted afterward. 8/20/17 (5:53 AM) Nursing Note - Foley leaking and catheter repositioned with no further leaking. Repositioning the foley increases the chance of a bladder infection.	F 315		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 37 8/21/17 (12:15 PM) Nursing Note - Excoriation to perineal area and abdominal folds continues without improvement. 8/22/17 (1:30 PM) Nursing Note - Nurse Practitioner notified of intermittent leaking of R15's foley. Orders to discontinue the 16 foley and replace with a size 18 with a 30 cc inflated balloon. New foley inserted without any difficulty. 8/24/17 (3:38 PM) Nursing Note - foley catheter replaced with 18 foley (a new foley was placed) due to non-drainage of urine. Every catheter insertion increases the chance of a bladder infection. 8/25/17 (12:04 PM) Nursing Note - Redness to abdominal folds showing signs of improvement. August 25 - 29, 2017 - Review of nursing notes found redness continued and no foley leakage. 8/30/17 (3:57 PM) Nursing Note - Redness to perineal area and upper inner thighs and abdominal folds improving. During an interview with E6 (UM) on 8/31/17 at 11:18 AM E6 stated that the resident requested it (foley) because she had a bad rash that was not improving. E6 went on to say R15 often refused to leave activities for incontinence care. 8/31/17 (12:12 PM) Nursing Note - Area to abdominal folds and perineal area continues to be red and catheter without complications. During an interview with R15 on 8/31/17 at 1:25	F 315		

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	085052	A. BUILDING _____ B. WING _____	09/05/2017

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F 315	Continued From page 38 PM the resident was not sure why s/he had the foley catheter and would rather not have it. 9/1/17- Discharged from Hospice services. 9/1/17 (2:39 AM) Nursing Note - Redness to abdominal folds and upper inner thighs still noted. Foley intact and draining without leaking. During an interview with R15 on 9/1/17 at 9:45 AM the resident said s/he did not want the catheter and did not feel like the area was getting better. 9/1/17 (11:43 AM) - During an observation of E21 (LPN) examining the area and repositioning the foley of R15, abdominal folds, perineal, and groin areas were noted as red, inflamed and R15 frowned as E21 touched the skin and repositioned the foley. During an interview with E10 (NP - wound care consultant) on 9/1/17 at 1:00 PM E10 said the foley was being used to encourage healing. When asked about alternative incontinent products E10 stated that liners were used for increased absorbency, barrier cream and leaving the brief open at night to alleviate moisture. E10 also stated that foley was for comfort care because R15 was under the care of hospice (R15 discharged from Hospice on 9/1/17). 9/1/17 (2:14 PM) Nursing Note - Foley repositioned for leaking. E22 (NP) wrote new orders for a 20 foley with a 30 cc balloon and Diflucan. New 20 foley placed without complications and sterility maintained. Pt denied discomfort and clear urine noted in catheter bag. Pt's niece was notified of the orders.	F 315		

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F 315	Continued From page 39 During an interview with E6 on 9/5/17 at 9:26 AM E6 said the resident did not like to miss activities and refused continence care. The resident requested the foley to promote the healing. When asked about alternative approaches and products, E6 said they have tried different products: an insert for the incontinent undergarment to increase absorbency, a larger brief, leaving brief open at night, Diflucan, antifungal powder and creams. During an interview with R15 on 9/5/17 at11:40 AM the resident said s/he did not refuse to be changed. R15 went on to say that this morning "I asked to not wear these pants and they put them on anyway. I wanted to be just covered with the sheet like yesterday." The facility initiated a foley catheter without exploring alternative less invasive options, placing R15 at risk for infection. Furthermore, on 4 separate occasions a foley catheter was inserted (in addition to 3 times the tube was repositioned) over the course of 15 days. Progress notes, care plans, behavioral flow sheets, and R15's statement did not support the need for the foley catheter These findings were reviewed with E (NHA) and E2 [DON] on 9/5/17 at 2:00 PM.	F 315		
F 406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and	F 406		11/6/17

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F 406	Continued From page 40 rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the specialized services according to the PASRR Level II evaluation for one (R11) out of 33 sampled residents. Findings include: Review of R11's clinical record revealed: 4/13/17 - PASRR Level II Determination of Mental Illness Recommendation documented that R11 required specialized services. The recommended services included that R11's mental health and related mental health medications must be monitored on an ongoing and monthly basis by a psychiatrist and supportive counseling to be provided by a licensed mental health professional. 5/22/17 - An initial consultation with the facility's contracted psychological services provider was conducted and E15 (NP) documented that R11 had a diagnosis of schizophrenia and "yelling out at times...some depression....She (R11) admitted to hearing things and being freighted at times had	F 406	a. R11 was not harmed by this deficient practice. Resident was evaluated by the contracted psychological provider upon discovery. b. All residents who that have a PASRR Level 2 Determination have the potential to be affected by this deficient practice. c. A root cause analysis was conducted and it was determined that the facility failed to provide specialized services to R11 based off of the PASRR Level 2 that was completed. The Social Worker will initiate a master list of all like residents who have a PASRR Level 2. This list will be given to the facility psychiatric provider so that psychiatry services are provided to all like residents. A facility wide audit was completed and no further issues were identified based off of this deficient practice. d. The Social Worker/designee will conduct weekly audits on all residents who have a PASRR Level 2 who require	

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F 406	Continued From page 41 a flat affect, poor eye contact and looked to have been tearful." 6/14/17 - Progress note written by E15 documented a follow up visit to the initial consultation and R11 "yelling out and disruptive behaviors. 7/21/17 - A quarterly medication reduction meeting was conducted by E16 (Psychiatrist) and R11's medication and diagnoses were reviewed. During an interview on 9/5/17 at 9:44 AM with E6 (RN and UM) it was confirmed that she was aware that R11's recommended level II services were to see a psychiatrist once a month. During an interview on 9/5/17 at 11:00 AM with E2 (DON) it was reported that R11 was seen by E15 and E2 questioned "does it have to be a psychiatrist?" During an interview on 9/5/17 at 11:04 AM with E6 it was confirmed that R11 did not receive any visits from either E15 nor E16 in the month of August, and was seen by E15 in May and June. During an interview on 9/5/17 at 12:20 PM with E3 (SW) it was confirmed that the facility was aware of R11's specialized services recommendations which included monthly monitoring by a psychiatrist. E3 reported she coordinated with E15 who works in conjunction with E16. E3 confirmed that the psychiatrist sees patients quarterly. According to R11's PASRR Level II evaluation service recommendations R11 should have special services that included monitoring on an	F 406	specialized services until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

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F 406	Continued From page 42 ongoing and monthly basis by a psychiatrist; the recommendation did not address the use of a NP in place of a psychiatrist. R11 received one visit from a psychiatrist in July, and 2 visits from the psychiatric NP with no visits from either documented for the month of August 2017. These findings were reviewed with E1 (NHA) and E2 [DON] during exit conference on 9/5/17 at 2:00 PM.	F 406		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		11/6/17

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F 441	Continued From page 43 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 44 Based on record reviews and staff interviews, it was determined that the facility failed to ensure that completed Tuberculosis (TB) screenings were done immediately upon admission for one (R148) out of 5 sampled residents reviewed. Three (E7, E8 and E9) out of 23 staff reviewed failed to have evidence of completed TB screening immediately upon hire. Findings include: The facility policy entitled TB Prevention and Control last updated 4/29/16, included the following information: skin test should be administered to new employees and residents. The CDC recommendations for Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly Recommendations of the Advisory Committee for Elimination of Tuberculosis indicates that "Skin tests should be administered to all new residents and employees as soon as their residency or employment begins." 1. R148 admitted to the facility 5/22/17 and did not receive a TB screening test until 6/12/17 which was 21 days after admission. 2. E7 (LPN) was hired on 7/5/17. The facility documented TB screening dated as of 7/7/17 which was 2 days after employment. 3. E8 (SPS) was hired on 7/11/17. The facility documented TB screening dated as of 7/27/17 which was 16 days after employment. 4. E9 (RN) was hired on 7/19/17. The facility documented TB screening dated as of 8/1/17 which was 14 days after employment. During an interview on 9/5/17 at 10:41 AM with E2 (DON) it was confirmed that R148 did not	F 441	1. a. R148 was not harmed by this deficient practice. b. All residents that require a TB Test have the potential to be affected by this deficient practice. c. A root cause analysis was conducted and it was determined that the facility failed to assure that R148 received a TB Test timely. The facility conducted an audit and it was determined that no additional residents were affected by this deficient practice. The Facility Nursing Management Staff will review each resident during Morning Meeting to monitor that each resident is given a TB test timely going forward. d. The Staff Educator/designee will conduct weekly audits on all residents who are admitted to determine when the PPD Test is given timely until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved. 2. a. E7, E8, E9 were not harmed by this deficient practice. b. All newly hired staff have the potential to be affected by this deficient practice. c. A root cause analysis was conducted and it was determined that the facility failed to assure that E7, E8, E9 received a TB Test timely. The facility conducted an audit and it was determined that no additional staff members were affected by this deficient practice. The Staff	

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F 441	Continued From page 45 receive TB screening upon admission. E2 explained E8 had a chest x-ray dated 12/30/15 from previous employment so initially the facility was not going to perform a TB screen. E2 then confirmed E7 and E9 dates of TB screening was after their start dates. These findings were reviewed with E1 (NHA) and E2 during exit conference on 9/5/17 at 2:00 PM.	F 441	Educator/HR Director collaboratively will review each new employee□s file upon hire to determine compliance with TB testing. d. The Staff Educator/designee will conduct weekly audits on all newly hired staff to determine that TB testing was completed until 100% compliance is achieved for 3 consecutive weeks, then weekly until 100% is achieved for 3 consecutive weeks, then audit quarterly for 3 consecutive quarters until substantial compliance is achieved.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Renaissance

DATE SURVEY COMPLETED: September 5, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from August 28, 2017 through September 5, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 110. The survey sample totaled thirty three (33).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 5, 2017: F242, F246, F279, F280, F282, F312, F314, F315, F406 & F441.	Cross Refer to the CMS 2567-L survey completed September 5, 2017: F242, F246, F279, F280, F282, F312, F314, F315, F406 & F441.	11/6/17

Provider's Signature [signature] Title NHA Date 9/19/17

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STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Renaissance

DATE SURVEY COMPLETED: September 5, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature _____ Title NHA Date 9/19/17